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TITLE I QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Effective Coverage for All Americans

Individual and Group Market Changes

Amends the Public Health Service Act to tighten regulations over private insurers and allow for guaranteed coverage and elimination of discrimination. Carriers are prohibited s from rejecting a person for coverage based on pre-existing conditions or other health status factors. Premiums can only vary by family structure, community rating area, actuarial value of the benefit and age (suggested ratio of variability of less than 2 to 1). The legislation relies on the National Association of Insurance Commissioners' recommendation of what the minimum size for community rating areas should be. Additionally, insurers cannot discriminate or set different rates based on gender, class of business, claims experience or any other factor that is not described. Guaranteed availability and renewablility of coverage is ensured, but the legislation does allow for a restriction on enrollment periods at the discretion of the insurer.

A report from the issuer is required on the percentage of total premium revenue that coverage expends on reimbursement for clinical services, improvement of quality, and other non-claims costs (along with an explanation of the report) in order to bring down the cost of coverage (exemption for those operating in their first year). For those plans not providing minimum qualifying coverage, plans must notify enrollees of this fact. The Secretary will advise on the best method of notification.

Reimbursement Structure for Improved Quality

Group health plans and individual plan carriers are required to develop and implement a reimbursement structure that provides incentives for high quality health care, including case management, care coordination, chronic disease management, and medication and care compliance. Additionally, the reimbursement structure must aim to reduce hospital readmissions through hospital discharge programs that include patient-centered education and counseling, comprehensive discharge planning and post discharge reinforcement. Issuers should aim to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine and health information technology, the inclusion of child health measures, and must use culturally and linguistically appropriate care. These reimbursement structures should substantially" reflect the payment policy of Medicare, SCHIP and Medicaid.

Preventive Health Services

There is no cost sharing for coverage of preventive health services. Specifically, issuers will have no cost sharing requirements for any items or services rated "A" or "B" under the current U.S. Preventive Services Task Force recommendations. Additionally, immunizations recommended by the Advisory Committee on Immunization Practices of the CDC will have no

cost sharing requirements. Finally, preventive care and screenings supported in the guidelines issued by HRSA for infants children and adolescents will have no cost sharing requirements.

The Secretary will issue guidance on the minimum amount of time between a recommendation is offered and what is covered under a plan, but it will be no less than one year.

Any coverage that allows for an insured's dependent that the coverage be extended until that dependent is 26 years of age and lifetime and/or annual caps on coverage are eliminated.

Provision Applicable to Group Market

Prohibits discrimination based on salary.

No Change to Existing Coverage, Conforming Amendments

Those who are happy with their insurance coverage can keep it, and family members can join existing coverage.

Provides for a special rule for collective bargaining agreements that the insurance provided as part of that agreement is considered "qualifying" until the date of the last agreement's termination or one year after the legislation becomes law.

The legislation includes conforming amendments to change the PHSA to include both group health plans and allow for individual health plans, effective immediately upon the legislation becoming law. PHSA changes with respect to a state become effective when the state enacts or modifies its laws to conform with the legislation, or 4 years from the date of enactment.

Available Coverage for All Americans

The legislation assumes that those currently eligible for Medicaid will remain so, and assumes an extension in eligibility for those with incomes up to 150% of the federal poverty level (FPL). It also assumes that the enrollment process will be streamlined, the state will be required to maintain the eligibility level for those currently enrolled, and allows for the Gateways to determine eligibility for federal programs. Additionally, the Federal government will pick up 100% of the cost to states for enrollment costs until 2015, when the share will be phased down and finally out by 2020.

The legislation finds that the Federal Employees Health Benefit program (FEHB) should serve as a model and standard for choice in coverage, and that all people should have access to similar choices.

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Affordable Choices for All Americans

American Health Benefits Gateway
Establishes the American Health Benefits Gateway and provides grants to states for the planning and establishment for the facilitation of a Gateway. Formula-based grants will be available to states within 60 days. The formula will be calculated based on a minimum dollar amount per state as well as an amount based on the state's population.

The legislation defines an American Health Benefit Gateway as a mechanism that facilitates the purchase of health coverage and related insurance products through the Gateway at an affordable price by qualified individuals and employer groups, giving the individual the choice to enroll or not in a qualified plan or to participate in the Gateway.
Gateways are established by a state or the Secretary if a State fails to act and must make qualified plans available to individuals and groups. The Gateway will include a public health insurance option. *While AACOM has not taken a position on the inclusion of a public health insurance option, the HELP Committee has included it. The Finance Committee legislation when released may have a different approach to a public option.*

Gateways must establish procedures for the certification, re-certification or de-certification of qualified health plans, develop and make available tools for consumers to obtain accurate information on the expected premiums, availability of in-and-out-of network providers, costs of surcharges, the amount of preventive services offered through the plan, information on cost and experience, and the use of administrative simplification measures and standards.

To pay for the administrative functions of the Gateway, it can assess surcharges on health insurers that offer qualified plans through it, but the surcharge shall not exceed 3% of the premiums collected by the plan.

To equally distribute the risk adjustment and entice plans to cover those with higher actuarial risk, plans with a less than average actuarial risk will pay a fee while those with greater actuarial risk will get money back.

Gateways will also be responsible for identifying individuals who lack coverage and assist with enrollment in a qualified plan, Medicaid, SCHIP, or other federal program. For those eligible for CHIP, the parent has a choice between enrolling their child in CHIP or in a plan through the Gateway.

Gateways will be responsible for certifying plan, will not employ marketing practices that discourage enrollment, ensure simplicity comparability and ease of consumer choice, make available a description of benefits, service area, required premiums, cost-sharing requirements, access, and grievance and appeals procedures. Plans will be accredited by the National Committee for Quality Assurance or other similar entity.

HIT Grants for Interoperability

The Secretary will coordinate with the Office of the National Coordinator for Health Information Technology (ONCHIT) to develop interoperable, secure, scalable and reusable standards and protocols that facilitate enrollment in federal and state programs. Coordination will include electronic matching against existing data and the capability for individuals to apply, recertify, and manage eligibility information online. Grants will be available for states to work with vendors to develop these electronic systems, establish statewide help lines for enrollment assistance and referrals and to establish public education and awareness campaigns that target the uninsured and underserved communities. Grants will also be available to community-based organizations for infrastructure and training to establish electronic assistance programs.

Health plans will be certified that they meet the qualifying criteria set forth by the Secretary and if the Gateway determines that the plan meets the interests of qualified individuals and employers in the states. The Secretary will offer guidance on the subject.

A Gateway can operate in more than one state, as long as the states involved allow it. States can establish one or more subsidiary Gateways as long as each Gateway serves a geographically distinct area and is served at least as large a community rating area.

Internet websites will be established by the Secretary to determine where Gateways are operating.

Choice is available in that individuals and employers can enroll in and may provide support for any of the qualified plans offered through the Gateway. Employers can specify a tier the employee must choose from. Self-employed individuals can participate as an employer or an individual.

The market can continue to operate outside of the Gateway, and individuals can enroll in non-qualified health plans if they so choose. States can continue existing requirements with respect to benefits.

Plan Certification

The Secretary will establish criteria for qualification through the rulemaking process. However, to be certified a plan must not discourage enrollment by those with significant health needs, ensure that products offered are simple and comparable, ensure a wide choice of providers, include information on the maximums, limitations exclusions and benefit limitations on the service area premiums cost sharing requirements access to providers and the grievance and appeals process; provide coverage for at least essential benefits established un Section 3103; be accredited by the National Committee for Quality Assurance or a similar entity; implement quality improvement strategy; have procedures in place for appeals of coverage determinations and may not adopt a benefit design that is likely to discourage enrollment by certain individuals.

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Incentives for Improving Quality and Reducing Hospital Readmissions

Legislation provides for incentivizing quality improvement, including increased reimbursement for improving health outcomes through quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, use of the medical home, prevention of hospital readmissions though a comprehensive program for hospital discharge including patient-centered education and counseling, discharge planning and the implementation of wellness and health promotion activities. The Secretary will develop guidelines for this process. *Because of the focus on care coordination, chronic disease management and the medical home, this initiative may greatly impact primary care; if this provision is included in the final Senate bill, we will continue to monitor this as the Secretary provides more detail.*

Beginning January 1, 2012 qualified plans may contract with a hospital with over 50 beds if it utilizes a patient safety evaluation system, implements a comprehensive program for hospital discharge, including education and counseling, discharge planning and post discharge reinforcement. Plans can also contract with providers if they implement mechanisms that improve health care quality.

Financial Integrity of Gateways

States will account for all activities with respect to the Gateway. The Secretary can investigate and/or audit a Gateway. Should the Secretary find abuse, a Gateway can be fined and the Secretary can rescind payments up to 1% per year until corrective actions are taken. The GAO must conduct a study within 5 years of Gateway activities.

Medical Advisory Council

The Secretary, along with the NIH and CDC, will establish a Medical Advisory Council to make recommendations on essential health care benefits, and minimum qualifying coverage.

Members will be appointed by the Secretary to serve 3 year terms for not more than 2 terms. Reports by the Council will be reviewed by the Secretary and Congress. Recommendations will be made on:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse services
- Prescription drugs
- Rehabilitative, habilitative and laboratory services
- Preventive and wellness services
- Pediatric services (oral and vision included)
- Criteria coverage must meet to be considered “qualifying”

- What is considered "affordable" and "available"

State Flexibility

States have four years after enactment to establish a Gateway and adopt the insurance reform provisions. However, States can also request that the Secretary operate the Gateway in the state for a minimum of 5 years, or may not elect to establish a Gateway at all. If a State does not establish a Gateway after four years, the Secretary is required to establish and operate a Gateway in the State, and all insurance reform provisions become effective, deeming the State as "participating."

Navigators

The Secretary will award grants to States that establish Gateways to enter into agreements with private and public entities so that those entities can service as navigators. Eligible entities have an existing relationship with employers, employees, and self-employed individuals who will likely participate in the Gateway. Navigators will conduct public education activities, distribute fair and impartial information about qualified health plans, help with enrollment and provide other information, such as culturally and linguistically appropriate materials. Grantees could include:

- Trade, industry and professional associations
- Commercial fishing industry organizations
- Ranching and farming organizations
- Chambers of commerce
- Unions
- Small business development centers
- Other as the Secretary determines

Grantees **cannot** be:

- A health issuer
- Receive consideration from any health insurance issuer in connection with the participation of any employer or eligible employee in coverage

Medicaid/SCHIP eligibility

If an individual is determined to be eligible for Medicaid in the process of applying for coverage through the Gateway, the State must establish procedures for advising the individual of their coverage options and determining whether the individual is eligible and if so the amount of credits, and submit to a qualified health plan those credits for the individual to enroll in their chosen plan.

Levels of Cost Sharing

The Secretary will establish three tiers of cost sharing.

- Basic Plan: will provide coverage for at least 76% of the provided benefit.
- Tier II: cost sharing is equal to the basic plan's benefit plus 8% and an out of pocket limit of 50% of the basic plan's out of pocket limit.
- Tier III: cost sharing is equal to the basic plan plus 17% and an out of pocket limitation set at 15% of the out of pocket limitation for the basic plan.

The Secretary has the authority to allow for variability in these costs once a year, but not more than 2 percentage points for cost sharing or 5 percentage points for out of pocket value.

Premium credits through the Gateway (subsidies to purchase insurance coverage)

The Secretary will pay premium credits to the Gateway on the individual's behalf for qualified health coverage. Credits are available for those up to 500% of the federal poverty level on a sliding scale from 150%. For those below 150% FPL the amount the individual is responsible for is reduced to 1% of the income.

The Secretary will establish procedures to determine eligibility, an application for coverage including options for electronic submission of application and enrollment. Eligibility determinations will be based on income in the previous tax year. The Secretary can delegate eligibility determination authority to the Gateway.

Small Business Health Options Program Credit

Beginning 2010 qualified small businesses can received premium credits from the Secretary in the amount of $1,000 per employee for individual coverage, $2,000 per employee for family coverage; and $1,500 per employee for two adults or one adult and one or more children through employer. The amount increases by $200, 400 and 300 for each additional 10% of expenses over 60% employer pays. Premiums are determined by an employee size factor which phases out in increments until a business has more than 50 employees. Qualified small employer is defined as those that purchase health insurance in a small group market in a Gateway, pays at least 60% of the qualified employee health insurance expenses, or who is self-employed and has fewer than 50 employees or earns less than $5,000 net or $15,000 gross earnings if self-employed, up to $50,000 in net or $150,000 in gross earnings. Employers may not receive a credit for more than three consecutive years.

Shared Responsibility for Health Care

Beginning December 31, 2010, an individual must pay if they do not obtained qualified coverage, unless the gap in coverage is for less than 90 days, the individual can prove no affordable coverage is available to them, is part of a federally recognized Indian tribe, can prove that purchasing a qualified plan would represent an exceptional hardship or they live in a state

that has not established a Gateway. The Secretary will issue guidance on the fine amount by June 30. Individuals will report their coverage on their tax return.

Employers must inform their employees within 90 days of enactment written notice of the existence of the American Health Benefits Gateway. Other options for employers' shared responsibility is currently still under discussion.

Definitions

Public Plan

The availability of a public health insurance option is still under discussion.

Qualified Individual

A qualified individual is a citizen or national of the U.S., an alien lawfully admitted to the U.S. for permanent residence, enrolled in a qualified health plan, not covered under Medicaid, SCHIP, Medicare, TRICARE, the FEHB plan, or other employer-sponsored insurance.

Qualified Employer

A qualified employer is one who elects to make full-time employees eligible for a qualified health plan.

Qualified Health Plan

A qualified health plan is which has a certification that meets the Secretary's criteria for certification, is offered through the Gateway, is licensed and in good standing to offer coverage, offers at least one qualified health plan in the two bottom tiers and pays the agreed surcharge to the Gateway.

Improving Access to Health Care Services

Spending for Federally Qualified Health Centers (FQHCs)

Authorizes the appropriations for FY 2010 through 2015 as follows:

- FY 2010 $2,988,821,592
- FY 2011 $3,862,107,440
- FY 2012 $4,990,553,440
- FY 2013 $6,448,713,307
- FY 2014 $7,332,924,155
- FY 2015 $8,332,924,155

Funding for National Health Service Corps (NHSC)

Authorizes the appropriations for FY 2010 through 2015 as follows:

- FY 2010 $320,461,632
- FY 2011 $414,095,394
- FY 2012 $535,087,442
- FY 2013 $691,431,432
- FY 2014 $893,456,433
- FY 2015 $1,154,510,336

Both the Community Health Center program and the NHSC are reauthorized at higher levels than their current authorizations, and this legislation provides for significant growth in these programs.

Negotiated Rulemaking for Development of Methodology and Criteria for Designating Medically Underserved Populations and Health Professions Shortage Areas

The Secretary is required to establish through negotiated rulemaking the above mentioned methodology and criteria. To do this, the Secretary shall consult with relevant stakeholders and shall consider the availability and appropriateness of data, the impact of the methodology and criteria on communities and safety net providers, the degree of ease or difficulty that will face potential applicants and the extend to which the methodology accurately measures barriers. A notice of this rulemaking shall be published no later than 45 days after the passage of this Act; the target date for the publication of the negotiated rulemaking is July 1, 2010.

Making Health Care More Affordable for Retirees

Reinsurance for Retirees

The Secretary shall establish a temporary reinsurance program to provide reimbursement to eligible employers in any State that is not a participating or establishing State for the cost of providing health insurance to retirees between the ages of 55 and 64 during the period between the date the program is established and the date on which the State becomes a participating or establishing State.

Participating employers are those that provide employer-sponsored health insurance coverage for individuals between the ages of 55 and 64 who are not active employees of the employer and who are not eligible for coverage under Medicare and submit an application to participate in the program.

Improving the Use of HIT for Enrollment

HIT Enrollment Standards and Protocols

The Secretary in consultation with the HIT Policy Committee and the HIT Standards Committee shall develop interoperable and secure standards and protocols that facilitate the enrollment of individuals in Federal and State health and human services programs within 180 days of enactment.

The standards and protocols shall allow:

- Electronic matching against existing Federal and State data;
- Simplification and submission of electronic documentation, digitization of documents and systems verification of eligibility;
- Reuse of stored eligibility information;
- Capability for individuals to apply, recertify and manage eligibility information online;
- Ability to expand enrollment system to integrate new programs, rules and functionalities;
- Notification of eligibility, recertification, and other needed communication regarding eligibility;
- Other functionalities needed to streamline the enrollment process.

States and other eligible entities shall submit applications to the Secretary to receive grants to implement new HIT enrollment standards and protocols.

Community Living Assistance and Supports Act (CLASS)

This subtitle creates a new entitlement program for purchasing community living assistance services and support. It sets up a CLASS Independence Advisory Council made up of 15 people appointed by the President who represent those who would participate in the program, CLASS Independence Fund with lock-box protection, and CLASS Independence Benefit Plan, which includes the option of two actuarially sound plans for consideration.

Individuals are eligible for the entitlement if they have a functional limitation for more than 90 days, are unable to perform a minimum number of activities of daily living, and require substantial supervision. The amount of the entitlement is no less than $50 per day with no lifetime limit. This is a coordinated benefit with other federal or state benefits.

Individuals will be automatically enrolled with an opt-out option. The CLASS program is meant to supplement, not supplant, other benefits.

TITLE II – IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

National Strategy to Improve Health Care Quality

National Strategy

The Secretary will be responsible for developing a national strategy to improve the delivery of health care services, patient health outcomes and population health. This strategy will address the following:

- Patients with high-cost chronic diseases;
- Develop and adopt infrastructure and methods for quality improvement in the health care delivery system to improve patient safety;
- Improve outcomes, efficiency and the patient-centeredness of care;

- Reduce health disparities;
- Address gaps in quality and health outcomes measures;
- Identify areas that have the potential to rapidly improve the quality of patient care;
- Improve payment policy to emphasize quality; and
- Enhance the use of health care data to improve quality and outcomes.

The plan will address coordination among agencies within HHS, include agency specific plans, establish benchmarks for each agency, a process for reporting on implementation of the plan and incorporate quality improvement and measurement for HIT as required by ARRA.

Interagency Working Group on Health Care Quality

The Working Group (convened by the President) will collaborate on planning and implementing the national strategy. By December 31, 2010, the Working Group will submit its first annual report to Congress outlining the progress and recommendations of the Group.

Quality Measure Development

Quality measures will be developed to fill the gaps between already developed measures. When identifying gaps, the areas identified by consensus-based organizations will be considered. This information will be published online. Grants will be available for developing new or updating existing measures. In awarding the grants, priority will be given to measures that allow the assessment of health outcome and functional status of patients, the continuity and management of care transitions, the experience of patients and caregivers, the safety, effectiveness and timeliness of care, health disparities, the appropriate use of health care resources and services and the use of innovative strategies and methods. For FY 2010 through FY 2014, $75 million is authorized to develop quality measures.

Quality Measure Endorsement; Public Reporting; Data Collection

Grants and contracts will be available to qualified consensus-based entities to make recommendations for national priorities, identify gaps in endorsed quality measures, identify and endorse quality measures, update endorsed quality measures at least every 3 years and make endorsed quality measures publicly available. Those entities receiving grants and contracts will provide an annual report to the Secretary. Within 5 years of enactment, the Secretary will implement a reporting system for quality measures, and performance information summarizing the data on quality measures will be made publicly available online. The GAO will evaluate the data collection processes and report to Congress.

Collection and Analysis of Quality Measure Data

There will be a process to collect, validate and aggregate data on quality measures, and grants will be available to entities to do this. For FY 2010 through FY 2014, $75 million is authorized to do this.

Health Care Quality Improvements

Health Care Delivery System Research; Quality Improvement Technical Assistance

The Patient Safety Research Center will be established to strengthen best practice research and dissemination, translating best practice into sustainable improvements. The Center will also be responsible to support research on delivery system improvement and tools that improve quality and patient safety. Findings will be publicly available and must be shared with the Office of the National Coordinator for Health Information Technology. Technical assistance awards will be distributed to entities to support institutions and providers delivering care.

Grants to Establish Community Health Teams to Support a Medical Home Model

Community health teams will be established to support primary care practices to become medical homes. All teams applying for grants will be State or State-designated entities and must submit a plan for achieving financial sustainability within 3 years. Teams must be multidisciplinary and interprofessional and have a plan for prevention initiatives, patient education and care management.

Grants to Implement Medication Management Services in Treatment of Chronic Disease

The Patient Safety Research Center will provide grants to implement medication management services provided by licensed pharmacists as an inter-professional approach to treating chronic diseases, improving the quality of care and reducing costs. Individuals who take 4 or more prescribed medications, any high risk medications, have two or more chronic diseases or have undergone a transition of care will be targeted for this program. The Secretary will submit a report evaluating this program to Congress.

Reducing and Reporting Hospital Readmissions

Beginning in 2010, the Secretary will analyze and calculate hospital-specific and national readmission rates. A year later the Secretary will provide confidential disclosure to hospitals receiving funds under this Act on readmission rates, and not later than two years after enactment, the Secretary will make this information publicly available. The Secretary, CMS and AHRQ will select readmissions that were preventable with care consistent with evidence-based guidelines and those for conditions related to care provided during the prior admission during a period of no less than a week and no more than 30 days for selected conditions. Eligible hospitals will be able to improve their readmission rates through the use of patient safety organizations.

Program to Facilitate Shared Decision Making

Educational tools that help patients and caregivers understand and communicate about their treatment options will be developed. A program for which grants will be available will be established to develop and test these materials and educate providers on the use of these materials. Grants will also be available for providers for the development and implementation of

shared decision making techniques. Quality measures related to the utilization of these tools and patient and provider experiences will be developed.

Center for Health Outcomes Research and Evaluation

The Secretary will establish the Center for Health Outcomes Research and Evaluation to collect, conduct, support and synthesize research comparing health outcomes, effectiveness and appropriateness of health care services and procedures. An advisory council with representatives from the scientific research, patient, provider and health industry communities will be established to ensure transparency. *This is the HELP Committee approach to comparative effectiveness research (CER). There is an effort underway to strip this provision from the bill. We anticipate the Finance Committee will include a separate provision on CER.*

Demonstration Program to Integrate Quality Improvement and Patient Safety Training into Clinical Education of Health Professionals

Grants will be awarded for demonstrations projects to develop and implement academic curricula that integrate quality improvement and patient safety into health professionals' clinical education.

Office of Women's Health

The Act makes the women's health offices within HHS and its agencies permanent.

TITLE III: IMPROVING THE HEALTH OF THE AMERICAN PEOPLE

Modernizing Disease Prevention of Public Health Systems

National Prevention, Health Promotion and Public Health Council

The President will establish the "National Prevention, Health Promotion and Public Health Council," which will be an interagency council that will provide coordination of prevention, wellness and health promotion practices at the Federal level. The Chair will be responsible for developing and publicizing a national prevention and health promotion strategy, and the Council will be responsible for reporting its progress on implementation to Congress annually.

Prevention and Public Health Investment Fund

The Investment Fund will provide an expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs. For FY 2010 through FY 2019, the Act authorizes the appropriation of $10 billion for the activities of the Investment Fund.

Clinical and Community Preventive Services

The Preventive Services Task Force will review the scientific evidence related to the effectiveness, appropriateness and cost-effectiveness of clinical preventive services for the purpose of developing recommendations to be published in the Guide to Clinical Preventive Services. The Community Preventive Services Task Force will review the scientific evidence related to the effectiveness, appropriateness and cost-effectiveness of community preventive interventions to develop recommendations to be published in the Guide to Community Preventive Services. Both Task Forces are instructed to coordinate their efforts.

Education and Outreach Campaign Regarding Preventive Benefits

Direct the Secretary to plan and implement a national public-private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the life span. Such sums as may be necessary are authorized to be appropriated for these activities.

Increasing Access to Clinical Preventive Services

Right Choices Program

States will be awarded grants to establish a Right Choices Program to provide preventive services to uninsured adults. Those eligible for the program will receive a one-time health risk appraisal and a risk-stratified care plan from a primary care professional participating in Medicare or Medicaid or who is a safety net provider. The care plan will recommend behavioral changes, referrals to community-based resources, referrals for age and gender appropriate immunizations and screenings to prevent chronic diseases. Those individuals diagnosed with an illness will be referred for treatment to Federal or State safety net providers. Providers will be reimbursed by the State.

School-Based Health Clinics

Authorizes a grant program for school-based health clinics that provide comprehensive primary health services during school hours and 24-hour coverage through an on-call system to medically underserved children. The clinic will coordinate health services with school personnel.

Oral Healthcare Prevention Activities

Through the CDC, the Secretary will establish a 5 year national, public education campaign focused on oral healthcare prevention and education, targeting children, pregnant women, parents, the elderly, individuals with disabilities and ethnic and racial minority populations. Demonstration grants will be awarded to entities to demonstrate the effectiveness of research-based dental disease management activities. Surveillance capacity is strengthened.

Creating Healthier Communities

Community Transformation Grants

Grants will be awarded to eligible entities for the implementation, evaluation and dissemination of proven evidence-based community preventive health activities to reduce chronic disease rates, address health disparities, and develop a stronger evidence-base of effective prevention programming. Grantees will formulate community transformation plans to promote wellness activities within the community and must submit an annual evaluation of activities carried out under the grant. *This appears to be a program that if included in the final legislation will provide an opportunity for COMs to participate.*

Healthy Aging, Living Well

Creates a 5-year pilot programs to provide interventions, screening and clinical referrals for the pre-Medicare eligible population of individuals aged 55 to 64. Intervention activities may include efforts to improve nutrition, increase physical activity, reduce substance abuse, improve mental health and promote healthy lifestyles; screening may include those for mental health, physical activity, smoking and nutrition and other measures designated by the Secretary. *This appears to be a prevention program that relates to the work of primary care providers and potentially the medical home.*

Wellness for Individuals with Disabilities

Within 9 months of enactment, standard must be set articulating the minimum technical criteria for medical diagnostic equipment used in medical settings to ensure the equipment is usable by those with disabilities.

Immunizations

States can purchase adult vaccines provided under grants within this section. A demonstration program will be established through the CDC to improve the provision of recommended immunizations for children, adolescents and adults.

Nutrition Labeling of Standard Menu Items at Chain Restaurants and of Articles of Food Sold from Vending Machines

Food sold at restaurants with 20 or more locations shall make a nutrient disclosure statement and a statement concerning suggested daily caloric intake.

Support for Prevention and Public Health Information

Research on Optimizing the Delivery of Public Health Services

The Secretary, acting through the CDC, will provide research funding in the area of public health services and systems. The research will examine best practices for prevention, analyzing the

translation of interventions from academics to clinics and communities and identifying effective strategies for delivering public health services in real world settings.

Understanding Health Disparities: Data Collection and Analysis

Any federally conducted or supported health care or public health program, activity or survey will be required to collect and report data by race, ethnicity, geographic location, socioeconomic status, health literacy, primary language and any other indicator of disparity. The Secretary is required to analyze the data and monitor trends in health disparities.

Health Impact Assessments

Establishes a program at the National Center of Environmental Health at the CDC to foster advances and provide technical support in the field of health impact assessments.

CDC and Employer-Based Wellness Programs

The CDC will conduct targeted educational campaigns to make employers aware of the benefits of employer-based wellness programs. The CDC will provide employers with technical assistance to evaluate these programs. After 2 years, the CDC will conduct a national worksite health policies and programs survey to assess employer-based health policies and programs. The CDC will conduct workforce demonstration studies to expand the science base for effective prevention and health promotion approaches in the workplace.

TITLE IV: HEALTH CARE WORKFORCE

This title aims to improve access to and the delivery of health care services for all individuals, particularly low income, underserved, uninsured, minority, health disparity and rural populations. Data will be gathered and assessed in order to have the health care workforce meet the health care needs of individuals. The supply of a qualified health care workforce will be increased to improve access to and the delivery of health care services. The education and training of the workforce will be enhanced.

Innovations in the Health Care Workforce

National Health Care Workforce Commission

Establishes a National Health Care Workforce Commission that serves as a resource to Congress and the President by reviewing national workforce needs and advising how to align those needs with workforce resources. The Commission will be responsible for reviewing current workforce supply and distribution, education and training capacity, the implication of Federal policies affecting the workforce, and the workforce needs of special populations. Congress is charging the Commission to examine the following high priority areas: workforce planning, the demands for the health care workforce in the enhanced information technology and management workplace, GME policies, nursing workforce capacity, oral health care workforce capacity, mental and behavioral health workforce capacity, allied health and public health care workforce

capacity, and the geographic distribution of health care providers. The Commission will be composed of 15 members appointed by the Comptroller General and who will serve for 3 year terms. *This provision creates the Commission that would oversee national workforce needs, and there may be an opportunity for AACOM or representatives of the COMs to serve on this Commission.*

State Health Care Workforce Development Grants

A competitive grant program is established to enable State partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies. Planning grants awarded under this provision for no longer than a year with a maximum award of $150,000.

Health Care Workforce Program Assessment

The National Center for Health Care Workforce Analysis is established to collect, analyze and report data related to Title VII programs. Its work will be done in coordination with the State and Regional Centers for Health Workforce Analysis. The Center will be responsible for evaluating the effectiveness of Title VII programs, developing and publishing benchmarks for these programs, and maintaining a publicly available national health workforce database. The Act authorizes $5 million in FY 2010 and FY 2011 and $10 million for FYs 2012-14 for the Center. The State and Regional Centers are authorized at $4.5 million for FYs 2010-14. *This provision speaks directly to the need to collect and analyze data on Title VII to determine its effectiveness for which AACOM has advocated.*

Increasing the Supply of the Health Care Workforce

Federally Supported Student Loan Funds

The federally supported student loan program is modified such that interest will accrue only on the unpaid balance of the loan computed only during periods for which the loan is repayable. For loans for medical school and primary health care, the law is amended such that repayment occurs during **practice in primary care for 10 years (including residency training) or** through the date on which the loan is repaid in full, whichever comes first; if the student is noncompliant, interest will accrue at a higher rate.

Health Care Workforce Loan Repayment Programs

Creates a loan repayment program for pediatric subspecialists and child and adolescent mental health providers. Individuals participating in this program agree to practice in these areas for a specified period of time. Priority will be given to applicants working in HPSAs, MUAs, or with MUPs. For FYs 2010 through 2014, $30 million is authorized.

Public Health Workforce Recruitment and Retention Programs

Creates the Public Health Workforce Loan Repayment Program to assure there is an adequate supply of public health professionals to eliminate public health workforce shortages in Federal, State, local and tribal public health agencies. $195 million is authorized for this program in FY 2010 and such sums as may be necessary for FYs 2011-15.

Allied Health Workforce Recruitment and Retention Programs

Assure an adequate supply of allied health professionals to eliminate shortages. Allied health professionals employed in a Federal, State, local or tribal public health agency or in other settings where patients might require health care services will be able to participate in a loan forgiveness program.

Grants for State and Local Programs

The Secretary can award grants to eligible entities to enroll in degree or professional training programs allowing mid-career professionals in the public health and allied health workforce to receive additional training. $60 million is authorized for FY 2010.

Nurse-Managed Health Clinics

Creates a $50 million grant program to support HRSA nurse-managed health clinics, strengthening the safety-net and ensuring that the medically underserved have access to care.

Elimination of Cap on Commissioned Corps

Lifts the cap of 2,800 currently in place.

Establishing a Ready Reserve Corps

Creates a Ready Reserve Corps within the Commissioned Corps to ensure personnel is available on short notice to meet both routine public health and emergency response missions.

Enhancing Health Care Workforce Education and Training

Training in Family Medicine, General Internal Medicine, General Pediatrics and Physician Assistantship

Provides 5 year grants to develop and operate training programs, financial assistance for trainees and faculty and faculty development programs. Opportunities are also provided to operate joint degree programs to provide interdisciplinary and interprofessional graduate training. Preference will be given to applicants establishing new academic unites or programs or those substantially expanding those units and programs. Applicants who are establishing collaborative projects, have a record of training and retaining primary care providers, working with FQHCs and

proposing innovative approaches (including the PCMH) will be given priority. For FYs 2010 through 2014, $125 million is authorized. *The HELP Committee did separate dentistry from this program and provides a significant increase in the authorized funding level of this program.*

Training Opportunities for Direct Care Workers

Grants will be awarded to entities providing training opportunities for direct care workers who are employed in long-term care settings. For FYs 2011 through 2013, $10 million is authorized.

Training in General, Pediatric and Public Health Dentistry

Takes the dentistry training grants and separates them from those for training in primary care medicine. Provides grants for training programs and creates a faculty loan repayment program in dentistry. For FYs 2011 through 2015, $30 million is authorized.

Alternate Dental Health Care Providers Demonstration Project

The Secretary is authorized to award grants to 15 eligible entities to establish a demonstration program to train dental providers to increase access in rural and underserved communities. Eligible entities will receive a $4 million grant for the 5 year demonstration period.

Geriatric Education and Training

Provides funding for grants and contracts to geriatric education centers to support training in geriatrics, chronic care management, and long-term care. Those centers receiving grants will be required to offer 2 course annually in family caregiver training and develop and include materials on depression and other mental disorders common among older adults. A maximum of 24 geriatric education centers will receive $150,000 awards. For FYs 2011 through 2014, $10.8 million is authorized.

Mental and Behavioral Health Education and Training Grants

Grants are available to schools for training programs in social work, graduate psychology, professional training in child and adolescent mental health and pre-service or in-service training of paraprofessionals in child and adolescent mental health. For FYs 2010 through 2013, $33 million, which is allocated between social work, graduate psychology, training in professional child and adolescent mental health and training in paraprofessional child and adolescent work, is authorized.

Cultural Competency, Prevention and Public Health and Individuals with Disabilities Training

Creates a program for the development, evaluation and dissemination of model curricula for cultural competency, prevention and public health proficiency and aptitude for working with individuals with disabilities for use in health professions schools and continuing education programs. *This presents a potential opportunity for COMs that we should monitor.*

Advanced Nursing Education Grants

Authorized nurse-midwifery programs are eligible to receive Title VIII grants.

Nurse Education, Practice and Retention Grants

Grants for nursing education, practice and retention are authorized for FYs 2010 through 2012.

Loan Repayment and Scholarship Program

Schools of nursing are eligible to participate in loan repayment and scholarship programs.

Nurse Faculty Loan Program

Creates a student loan repayment program for nurses pursuing careers in nurse education. To be eligible, nurses must agree to teach at an accredited school of nursing for 4 years within a 6 year period.

Grants to Promote the Community Health Workforce

Authorizes a grant program to award states, public health departments, FQHCs and other nonprofits to promote positive health behaviors for population medically underserved communities. Entities receiving grants under this program are encouraged to collaborate with academic institutions and one-stop delivery systems. Programs receiving these grants are encouraged to implement an outcome based payment system that rewards community health workers for connection underserved populations with appropriate services.

Youth Public Health Program

Establishes a youth public health program to expose and recruit high school students into health careers with a focus on public health.

Supporting the Existing Health Care Workforce

Centers of Excellence

Reauthorizes the Centers of Excellence program at $50 million for FYs 2010 through 2015.

Health Care Professionals Training for Diversity

Loan repayment funds for those serving as faculty are increased from $20,000 to $30,000. Funding for scholarships for disadvantaged students is increased from $37 million to $51 million in FY 2010. Both programs are reauthorized through FY 2014.

Interdisciplinary, Community Based Linkages

Supports training and education grants at Area Health Education Centers (AHECs). Infrastructure development awards allow entities to initiate or continue health care workforce educational programs; these programs should recruit individuals from underrepresented minority populations, provide community-based training and conduct interdisciplinary training. The innovative opportunities program recognizes programs that implement innovative criteria in community based settings, coordinate community-based participatory research and develop strategies to address identified workforce needs. The Secretary will award point of service maintenance and enhancement awards to entities maintaining and improving the effectiveness and capabilities of existing AHECs. For FYs 2010 through 2014, $125 million is authorized.

Continuing Educational Support for Health Professionals Serving in Underserved Communities

Eligible entities can receive grants to improve health care, increase retention, increase representation of minority faculty members, enhance the practice environment and provide information dissemination and education support to reduce professional isolation. For FYs 2010 through 2014, $125 million is authorized.

Workforce Diversity Grants

The scope of the workforce diversity grant program has been expanded to include stipends for diploma or associate degree nurses to enter a bridge or degree completion program, student scholarships or stipends for accelerated nursing degree programs as well as pre-entry preparation, advanced education preparation and retention activities.

Primary Care Extension Program

The Primary Care Extension Program will provide support and assistance to primary care providers to educate them about preventive medicine, health promotion, chronic disease management, mental health services and evidence based and evidence-informed therapies and techniques that can be incorporated into their practices. Grants will be awarded to States to establish State or multi-state level Primary Care Extension Program State Hub; these Hubs will assist providers to implement primary care medical homes and improve services. For FYs 2011 and 2012, $120 million is authorized